Surgical cases / [James Duncan].

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Duncan, James, 1810-1849.

Publication/Creation

Edinburgh : [publisher not identified], 1844]

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EXTRACTED FROM THE

NORTHERN JOURNAL OF MEDICINE

FOR NOVEMBER 1844.

SURGICAL CASES.

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Strangulated Femoral Hernia—Gangrene—Death.

JANE HUSBAND, æt. thirty, admitted on the 17th December 1843, was first seen by my friend Dr Douglas on the forenoon of the 17th, who, on ascertaining the nature of the disease under which she laboured, and finding that she could not be well attended to in her own house, recommended her removal to the hospital.

From the account which this patient gave, it would appear that she had been affected with femoral hernia of the right side for between three and four months, but that the bowel only descended occasionally.

Nine days previously to her admission she was seized with pretty severe pain of the abdomen occurring simultaneously with the appearance of the tumour in the right femoral region. The pain continued to increase, and the swelling in the groin likewise became the seat of considerable uneasiness. Vomiting shortly supervened; this after a time became stercoraceous, and the abdomen became somewhat tumid and tender to the touch. These symptoms continued, the tumour in the groin increasing, becoming red and more painful. On the 14th the vomiting ceased entirely, and was succeeded by occasional hiccup. Up to this date there had been no evacuation of the bowels, and there was none until the 17th, the day of her admission, when it was stated that there had been two scanty fetid evacuations. These, however, on examination were found to consist of some fetid fluid mixed with urine.

On the 17th, when I first saw this patient, she was in a very feeble condition, although perhaps not so much so as might have been expected in a person who had laboured for nine days under strangulation of the bowel. There was occasional nausea, but no vomiting. The abdomen was much distended, but not very tense, and the tenderness was by no means very great.

In the right groin there was a tumour of considerable size, as large nearly as a goose's egg. There was much surrounding condensation of the cellular tissue, and the integuments were of a dusky red hue, and pitted on pressure. Over a considerable portion of the tumour, deep-seated fluctuation, accompanied with an emphysematous crackling, was perfectly distinct. Slight percussion over the swelling elicited a clear sound. In appearance the swelling bore a very great resemblance to a neglected bubo, in which suppuration had taken place, and the integuments were threatening to slough. Pulse 95, small and weak; skin rather cold; tongue furred, brown, and rather dry.

Immediately after her admission a T-formed incision was made, and the parts divided down to the sac. This was next opened, and a small quantity of a dark fetid fluid escaped, having the characteristic gangrenous odour. A fold of small intestine of considerable size lay in the sac, a great portion of it was in a state of gangrene, and in one part the slough had separated, leaving an opening into the gut of about three-fourths of its circumference in extent. No feculent matter, and no discharge of any kind escaped from the bowel where it was exposed. There was no effusion of lymph between the bowel and the sac. The stricture was now examined, and found to be exceedingly tight. It was divided in the usual manner, and immediately a large quantity of fluid feculent matter was discharged by the opening formed by the separation of the slough. As the bowel was not adherent to the surrounding parts, I attached it to them by two points of interrupted suture, as I was afraid it might recede, and the feculent matter be extravasated into the cavity of the abdomen.

Shortly after the operation the woman expressed herself much relieved, and the distention of the abdomen rapidly subsided to a very great extent.

During the course of the evening the feculent matter continued to be discharged by the wound in considerable quantity. The patient continued in a much more comfortable state; the distention of the abdomen had diminished considerably, and the pain and tenderness were by no means great. The pulse and temperature of the skin continued much the same as before the operation, but the expression of collapse and anxiety had in a great measure disappeared.

18*th*, Continued in much the same state as at last report. The feculent matter continues to be evacuated by the wound,

but, as might have been expected, not in such large quantity as yesterday. Pulse 100; in strength much the same as before the operation. Tongue moist. No increase of pain or tenderness. Distention of abdomen much diminished.

Ht. ol. ricini, ℥ss.

19*th*, *Noon*. Had pretty copious evacuation by the wound this morning. Continues in all respects much the same as yesterday, and the abdomen bears pressure without producing pain.

8 *o'clock*, P. M. There has been no evacuation of feculent matter since the morning. About 4 P. M. there was considerable increase of the abdominal pain, and at present it is considerable. The distention has increased somewhat. There is much more expression of anxiety, and considerable restlessness, and she is troubled with occasional hiccup. Pulse 120—small, but wiry. Altogether there is a considerable change for the worse. Eighteen leeches were ordered to be applied, and calomel and opium were administered every three hours, but without relief. Matters went on from bad to worse, the pulse became intermitting, and she died on the afternoon of the 20th.

Post mortem, 21*st*. There were marks of extensive peritonitis. In the cavity of the pelvis there was a considerable quantity of serous effusion mixed with flakes of lymph. The intestines were matted together by recently effused lymph. Above the part implicated in the ring they were somewhat distended with flatus, but there was scarcely a trace of feculent matter. Below this point they were much contracted.

There were several circumstances in this case which at first tended to throw a little doubt over its real nature. This was, however, removed by further examination. The circumstances I allude to were, that some little time previously she had been affected with bubo, which had partially suppurated, and that at the time I saw her she had a profuse discharge from the vagina, attended with considerable irritation of the external parts. Then there was the report of the friends, that there had been feculent evacuation during the course of the day, and, lastly, there was the complete absence of vomiting for several days previously to our visiting her. Further examinations, as I have said, in a great measure removed any doubt. We found, as already stated, that the report of there having been feculent evacuation was incorrect; and on the mere absence of vomiting we could found but little, as it is known that, when gangrene of the bowel has ensued, the vomiting becomes less frequent, and in some cases ceases entirely, although the hiccup and distention of the abdomen continue as before.

As to the practice there could be no question; wherever doubt exists we must proceed on the supposition that the case is one of hernia. In describing the case, I have stated that when the bowel was exposed no feculent matter escaped, although the slough

had in part separated, and that in consequence I immediately divided the stricture, which was followed by copious evacuation. "The incessant vomiting, pain, restlessness, distress, and extreme constitutional disturbance," says Mr Lawrence, "are caused by the distention of the alimentary canal above the stricture, and will not cease until that is unloaded. The first and most urgent indication is to procure relief, which we should hasten to afford, even if it were simply to release a patient from a condition of most urgent suffering." Judging from what Mr Lawrence has written in his section on the treatment of mortified hernia, one would be led to believe that all that is necessary, in the majority of cases, to procure the desired evacuation, is the incision of the sac, and likewise, if necessary, a free incision through the mortified part of the gut. "It is well observed," he says, "by my friend Mr Travers, that the division of the stricture is unnecessary, for the bowel is already relieved, at the expense of its life indeed, by the natural process of mortification." Mr T., however, afterwards adds, "that should the stricture be so narrow as to interfere with the discharge, a small incision will afford the requisite room." I suspect that the division of the stricture will be found to be more frequently necessary than we would be led to believe by the above extracts. In femoral hernia of small size, I believe that the division of the stricture, under these circumstances, will be almost invariably necessary; the constriction in these cases being almost always so tight as to interfere with, if not altogether to prevent, the passage of feculent matter. My own experience is, of course, but limited; but still, in the only three cases of femoral hernia which I have met with in which the bowel was in a state of gangrene, and in which I operated, this was the case. In such cases, unless we divide the stricture, we might as well not operate at all, as we afford no relief to the patient, and scarcely diminish the chances of a fatal termination. I have mentioned that I retained the bowel in its position by two points of interrupted suture. Such a step may not have been absolutely necessary; but I was led to do so by the complete absence of any effusion of lymph, to prevent the bowel from retiring, and the fæces from escaping into the cavity of the abdomen. This may not have been absolutely necessary; but, under the circumstances, there was a danger that after the division of the stricture the bowel might recede. I have seen two cases operated upon, in both of which this had taken place, and a fatal result ensued; and, bearing these in my mind, I considered it right to adopt this precaution.

Strangulated Femoral Hernia—Operation—Artificial Anus—Death.

A. M'C., æt. forty-five, was admitted under my care on 22d April 1844. Was seen for the first time by Dr M. on the 19th of

April, in consequence of a swelling in the left inguinal region, in the situation of femoral hernia, and attended with the usual symptoms of strangulation. The tumour was about the size of a hen's egg, and pretty tense. The greater part was reduced by the taxis, but a small portion remained which it was impossible to return. The symptoms were, however, so much relieved, that no further attempt was made at the time. In about twenty-four hours they again returned with severity, and it being still found impossible to reduce the remaining portion, she was sent to the hospital, from about a distance of ten miles, to have the operation performed.

I saw her immediately after her admission. She was then considerably fatigued by the journey, but not so much so as to prevent her from walking from the cart, in which she had been conveyed, to the ward, a distance of about a hundred yards. On examination, a small hernial tumour of about the size of a walnut was found on the left side. The tumour was exceedingly tense, and was the seat of considerable pain. The general symptoms of strangulation were well marked. There was a good deal of distention and general tenderness of the abdomen, with much pain, referred chiefly to the umbilical region. She had frequent vomiting, though not of feculent matter, and the bowels had not been moved from the time when she was first visited. There was constant hiccup, and the face was pale, and expressive of much anxiety. The pulse was 120, small, and compressible. As the attempts at reduction had previously been fairly tried, they were not long persevered with, after it was found that they had no effect upon the tumour, and that they were productive of much pain. The woman, when the circumstances were explained to her, readily submitted to the operation.

The ordinary T incision was made, the sac opened, the stricture, which was exceedingly tight, divided, and a small knuckle of intestine, which was in good condition, returned without difficulty. When the finger was introduced after the reduction, a portion of intestine was found adherent to the peritoneum on the outer side of the ring, but not involved in the canal. All the pain and uneasiness of which the patient had complained disappeared shortly after the operation, and the vomiting and hiccup entirely ceased. An opiate was given, and during the course of the evening a dose of castor-oil.

23*d*. Has passed a pretty good night, but there has been no evacuation from the bowels. Pulse 100. Skin nearly natural. Distention of abdomen continues, but there is no tenderness on pressure. To have a large domestic enema. *Vespere*. No evacuation from the enema. Oil has been repeated. No return of the vomiting or hiccup. To have calomel gr. vi., ext. coloc. comp. gr. v., to be followed by a black draught.

24*th*. Still no evacuation. In other respects continues in

much the same condition. About lb. ij. of tepid oil were thrown up the rectum, and retained for some time, but were returned without any admixture of feculent matter. At the suggestion of Dr Abercrombie, and under the belief that the want of evacuation depended upon want of tone in the intestine at and above the part which had been strangulated, gr. iv. of the ext. coloc. c. with sulph. quinin. gr. j. were given, and ordered to be repeated every two hours until the bowels were moved.

25*th*. No return of the vomiting or hiccup, and no return of the tenderness of abdomen, although there is much uneasiness from the distention. The pills have been continued as ordered, but without the effect of producing any evacuation. Twelve leeches have been applied. Pills to be continued.

26*th*. There has been free evacuation from the bowels this morning, and the patient expresses herself as being in every respect much relieved. Pulse 100, weak. Distention of abdomen very much diminished. During the course of the evening there was again free evacuation from the bowels.

27*th*. There has again been evacuation this morning, but some feculent matter at the same time escaped by the wound, and has continued to be discharged from it since. The patient expressed herself as being free from uneasiness.

28*th*. Continues in much the same state as at last report. Pulse 100. In the evening there was some return of the pain and tenderness of the abdomen, with some acceleration of the pulse. The patient was believed to be too much reduced to admit of general bloodletting, but eighteen leeches were applied to the abdomen, and calomel gr. ii., with pul. opii gr. j., to be given, and repeated every three hours. From this time the patient got gradually worse, and died on the 1st May, the bowels having been once or twice moved in the interval.

Post mortem, May 2. The portion of bowel which had been strangulated was found adhering to the ring by recently effused lymph. This was so little tenacious that the mere raising of the intestine was sufficient to detach it. A perforation sufficiently large to admit the little finger, and evidently produced by sloughing, existed at the part where it lay in apposition to the canal. A portion of the sigmoid flexure of the colon was found likewise attached to the outer side of the ring, but evidently by adhesions of older date, although they were likewise easily broken up. There was some serous effusion in the cavity of the pelvis, mixed with a few flakes of lymph, but in very small quantity. The bowels above the part which had been strangulated were considerably dilated; but the most remarkable change was the general softening which they had undergone. Their coats were somewhat thickened, but so lacerable that by very slight force they were readily torn across, and the finger could be pushed through them with the greatest ease. No other morbid change was discovered.

This case is interesting from the length of time which elapsed between the performance of the operation and the evacuation of the bowels, and likewise from the subsequent formation of an artificial anus. In its progress, and likewise in some of the morbid changes, it appears to me to bear a very striking resemblance to those cases of ileus so well described by Dr Abercrombie. The bowels, after the division of the stricture, were long of regaining their tone, became over-distended, and the usual termination followed—intense inflammation of the affected parts, as indicated by the extremely softened and lacerable state of the whole canal above the point which had been constricted. A strangulated bowel may, subsequently to its reduction, give way at two points; it may give way, as a consequence of gangrene, in the part contained in the sac beyond the stricture; and, again, it may give way by the process of ulceration at the part which was embraced by the constriction, as followed in a case which I shall immediately relate. In the case I have stated that the bowel at the time of the operation appeared to be in pretty good condition: such a degree of inflammatory action, however, had been established as to terminate in gangrene, and the subsequent formation of an artificial anus. Such an occurrence is by no means rare; and we find, in the different works on hernia, cases in which the bowel has given way at a much more distant period than in the present. Some are related in which this had occurred after the lapse of several, even five or six, weeks.

Strangulated Crural Hernia—Reduction by the Taxis—Perforation by Ulceration after six Days—Death.

Mrs W., æt. forty-five. On the 5th October I visited this patient with my friend Mr Knox. She was then labouring under symptoms of strangulated hernia. The account given of the case was as follows:—On the 3d, she observed a small tumour in the left groin, but as it gave no uneasiness, no attention was paid to it. It continued in the same state during all that day and the next, the bowels having during that time been freely moved. Between the night of the 4th and the morning of the 5th it became painful, and shortly afterwards she began to complain of general pain of the abdomen, which during the night was accompanied with frequent vomiting.

She was seen by Mr Knox about 1 P. M. on the 5th, about nine hours after the symptoms of strangulation had commenced. The symptoms were then urgent. The hernial tumour was about the size of a walnut. It was tense and painful, and there was considerable general pain of abdomen, but no great distention. There had been frequent vomiting, and latterly this had become feculent. There was much anxiety; the face was pale, and the skin rather cool. The pulse was small, about 120, and easily compressed. Mr K. immediately employed the taxis,

and reduced the protrusion; but on returning about two hours afterwards, he found that the symptoms of strangulation continued, and I visited the woman along with him at 5 P. M. She was then very much in the same condition as already described, but there had been no vomiting for upwards of half an hour, the last ejections being as we found feculent. On examining the groin, the sac of the hernia alone could be felt. A large injection was now ordered. This was given, and returned without admixture with feculent matter; but in about half an hour there was a copious evacuation. I saw the patient along with Sir G. Ballingall and Mr K. at 7 P. M. She then felt much relieved, and there had been no return of the vomiting; but the abdominal tenderness still continued, and in other respects there was but little change.

6th, During the course of the night she had a second evacuation, but it was more scanty. No return of the vomiting. Abdominal tenderness much the same as yesterday. Pulse 120, small, feeble, and rather intermitting. From the great debility of the patient, who had laboured for some time under symptoms of cancer of the uterus, depleting measures were inadmissible; calomel and opium were in consequence prescribed, and ordered to be repeated every three hours.

The patient continued in much the same state until the evening of the 10th, the eighth day from the appearance of the tumour, and the sixth from its reduction, the bowels having been repeatedly moved during the interval. There had been no return of the vomiting, but the abdominal tenderness, though somewhat relieved, still continued.

On the evening of the 10th, she was seized with sudden increase of the pain. This was followed by rapid sinking, and she died on the morning of the 11th.

On the 12th, we had a post mortem examination.

On dividing the abdominal parietes a considerable quantity of fetid air escaped. A large quantity of fluid mixed with lymph and thin feculent matter was found in the pelvic region, and the intestines were matted together by recently effused lymph. The portion of intestine which had been strangulated was found slightly adhering to the abdominal parietes, about an inch and a half external to and below the crural ring. A transverse opening of about half an inch in length was found to exist in it, and to one side of this the bowel was dark-coloured, and evidently in a state approaching to gangrene. On the other side, at the part where the bowel had been adherent, it was covered with a thin layer of lymph. The opening was transverse, evidently produced by ulceration, and with the exception that its edges were slightly rounded, resembled very much what might have been made by a cut with scissors or a bistoury. Malignant ulceration of the uterus and upper part of the vagina existed to a considerable extent.

This case illustrates well the rapidity with which changes leading to fatal consequences may take place in strangulation of the intestine, and consequently inculcates strongly the danger of delay in having recourse to the necessary remedial measures. The patient had been seen by Mr W. Knox certainly within ten hours after symptoms of strangulation had manifested themselves, and the bowel was immediately reduced by him, but the mischief leading to the subsequent perforation of the intestine had already been effected. The case affords an example of the second mode in which perforation of the bowel takes place, which I have already alluded to,—that by ulceration at the point where it had been embraced by the stricture. This kind of perforation is by no means uncommon, and proves inevitably fatal from the intense peritonitis excited by the escape of the feculent matter into the cavity of the abdomen. This termination occurred in the case of a patient I was called to see some time ago, when she was in a moribund state, the case having been mistaken for one of mere constipation, and treated accordingly; and I have likewise in my possession a preparation, taken from a patient who had been under the care of my friend Mr J. Goodsir, in which a lesion of a similar kind is beautifully shown. The possibility of this occurring appears to me to afford an additional argument in support of the propriety of dividing the stricture in cases of mortified hernia when evacuation does not take place after the incision of the sac and bowel.

Strangulated Inguinal Hernia—Division of the Stricture outside the Sac—Cure.

J. S., æt. seventy, Jamaica Street.—I was called to see this patient late on the evening of the 21st February. He stated that he had been affected with inguinal hernia of the right side for a number of years. He had never worn a truss, the tumour had never occasioned any inconvenience, and until the morning of the day on which I saw him, he had never experienced any difficulty in returning it, little more being required than the assuming the horizontal position. For some days he had had no evacuation.

On going to bed the evening before, he had returned the hernia as usual, but on awaking about five o'clock in the morning he found that it had descended in increased volume, and that he was unable to reduce it. Shortly afterwards the tumour became the seat of considerable uneasiness, and he began to complain of twisting pain at the umbilicus. These symptoms, however, did not become so urgent as to induce him to send for assistance until the afternoon, the signs of strangulation being then fully established.

The tumour when I first saw him was of considerable size and very tense. It was exceedingly tender, and any attempts to re-

duce it gave considerable pain. There was but little distention of the abdomen, and very slight tenderness, but much complaint of twisting pain at the umbilicus. Vomiting had only commenced about two hours before I visited him, and was not yet feculent. Pulse 108. Skin moderately warm. Countenance expressive of much anxiety.

After the attempts at reduction which Sir G. B. and myself made, had, after what we considered a fair trial, failed, the circumstances of the case were explained to the man, and he readily submitted to the operation.

An incision of about three inches in length was made over the neck of the tumour, and the tendon of the external oblique exposed. It was at once seen that the external ring was the seat of the stricture. The constriction was exceedingly tight, and the edges of the ring were completely concealed by the projection which the tumour formed around them. I determined upon dividing it if possible without interfering with the sac. This was accomplished with facility by dividing the constricting parts with the point of the bistoury, these, from their state of tension, giving way at the slightest touch. The only difficulty met with arose from the edge of the ring being concealed by the bulging which the tumour made around it. This, however, was easily overcome by drawing down the tumour and compressing it with the point of the finger immediately below the point where it was wished to divide the stricture.

After about four or five lines of the tendon were divided in this manner, it was at once seen that the constriction was relieved, and the intestine was returned without the slightest difficulty. The edges of the wound were brought together by a few points of interrupted suture, and a compress and bandage applied. Within an hour after the operation the bowels were moved, and all the distressing symptoms entirely disappeared. From this time every thing went on well, and the greater part of the wound healed by the first intention.

In this case I followed the practice of dividing the stricture external to the sac,—a practice which, although ably advocated by Mr Key and others, and unquestionably in very many cases an exceedingly safe one, has been but too generally opposed. It appears to me to illustrate very well the facility with which in many cases this operation can be performed, and its comparative safety to that generally followed. The danger of wounds involving the peritoneum, more particularly if the parts are in a state of inflammation, is well known, and I have no doubt that had I in this case operated in the usual manner, the chances of recovery would have been much diminished. Every surgeon must have seen cases of hernia, operated upon under the most favourable circumstances, terminate fatally in consequence of the inflammation following the operation. I have myself seen many

terminate in this manner, in which no appreciable amount of inflammatory action existed at the time of the operation, and in which the fatal termination could, in my opinion, be ascribed to no other cause than the mode of operating, the laying open of the sac, the necessary exposure of its contents to the external air, the handling of the gut, &c. Several of these, and more than one on which I myself have operated, might, I have no doubt, have terminated differently had the practice I adopted in this case been pursued; and I am certain it might in several of them have been accomplished with great facility.

The arguments in favour of this operation, and the objections to it, have been very fairly stated by Mr Key in his memoir on this subject, and I have no doubt that were the practice more frequently tried, its efficacy would be established. There are very many cases in which the attempt to perform the operation in this manner would be improper if its performance were not impossible; but in many it might be attempted, I should say in most in which the attempt at reduction by the taxis is allowable. If we succeed, there is this great advantage that instead of a wound implicating important parts, we have simply an incision of the soft parts external to the sac, and attended with little more risk than if the protrusion had been returned by the taxis. If we fail, little or no harm is done. "A prominent character of the operation, and one that raises it above many of the objections that have been brought against it," is, as has been well said by Mr Key, "that should the attempt to execute it fail, either from want of dexterity on the part of the operator, or from any peculiar difficulty in the case, the operation can be completed in the ordinary way by laying the sac open."

"A surgeon may possibly find great and insuperable difficulty in dividing the stricture externally to the sac; or, having divided the stricture, he may be unable, by the best-directed efforts, to return the contents of the hernial tumour. In such a case, he has not brought himself into any dilemma by his unsuccessful attempt; the operation may proceed as if it had not been made; and neither patient nor surgeon is in a worse position than if the sac had been opened in the first instance without the attempt to preserve it entire. It is no slight recommendation of the operation, that its failure involves the surgeon in no embarrassment, but leaves him at liberty to adopt the old mode of operation."